LANCE H. BROWN, M.D.

ADELE D. HAIMOVIC, M.D.

DERMATOLOGY • MOHS SURGERY • COSMETIC DERMATOLOGY • LASER SURGERY

PATIENT INFORMATION FORM

Today's Date:_____(Please show all insurance cards to the front desk)

Patient Name: _____

Street Address: _____

City:_____State:_____Zip Code: _____

Telephone: (H)_____(C)_____(W)_____

Email: _____

Sex:__Male __Female Date of Birth: _____ S.S.#: _____

Marital Status: _____ Name of Spouse/Partner: _____

Emergency Contact:_____Relationship: _____

Phone: (H)_____(C)_____(W)_____

Are you employed?____Yes __No If yes, what is your occupation?_____

Name ofemployer: _____

Pharmacy: _____

Who referred you? _____

Insurance Information

What is the name of your PRIMARY insurance company?_____

Name of Insured: (If other then patient)_____Relationship:_____

Member I.D.#:_____ Group #: _____

What is the name of your SECONDARY insurance company?_____

_____

Name of Insured: (If other then patient)_____Relationship:_____

Member I.D. #:_____ Group #: _____

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CANCELLATION OR NO-SHOW FEE POLICY

In order to provide the best possible service and availability to all our patients, it is our policy to charge a fee for any appointment not cancelled at least 24 hours prior.

Medical Visit Cancellation or No-Show Fee: $150.00

- For medical visits, it is our policy to charge a fee of $150.00 for any appointment not cancelled/rescheduled at least 24 hours prior.

Cosmetic Procedure Cancellation or No-Show Fee: half the cost of the scheduled procedure

- For cosmetic procedures, it is our policy to charge a fee equal to half the cost of the procedure for any appointment not cancelled/rescheduled at least 24 hours prior.

Please call the office as soon as possible when you know you will need to reschedule your appointment. Thank you.

I have read and understand the above policies and I agree to be bounded by its terms.

Patient Name: _____

Patient Signature: _____ **Date:** _____

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PATIENT FINANCIAL OBLIGATION

Patient Billing Statements and Credit Card on File Policy

To better serve our patients and increase efficiency, we will no longer mail paper billing statements. Our practice management software has a patient portal that will allow patients to view statements and pay bills online. We also utilize text-to-pay as another convenient way to make payments.

This is how it works:

- Register for the patient portal.
- Once a new statement is generated, you will receive an email from us stating that you have a new statement in the patient portal. Please login to the portal and review and pay.
- If you do not pay you will receive a text from us in a few days with a link to pay your balance.
- If we do not receive your payment via either of these methods within 5 days after the statement was sent to the portal, we will charge the credit card you are required to leave on file with us.
- For patients with a balance higher than $400.00, we will make a courtesy call to you prior to charging your card. If we do not hear back from you within 72 hours, we will charge the card we have on file.

Why do we do this?

As part of our contract with your insurance company, balances are the patient's responsibility. We now require all patients to leave a credit card on file for any unpaid balances after the insurance company processes the claim. The online process improves convenience and efficiency for patients and our office.

Medicare Patients

We participate with Medicare and will not require a credit card to be left on file. However, if you do not have a secondary insurance, you must leave a credit card on file.

Commercial Insurance Patients

For all patients with commercial insurance, we require that you leave a credit card on file for any uncovered balances that may include co-pays, co-insurance, and deductibles as well as non-covered procedures. We do accept HSA cards and flex spending cards.

Self-Pay and Cosmetic Patients

Payment is due at the time of service. We are happy to store your credit card information for current date of service and or for future dates.

Deposits

We require a deposit for cosmetic consults and larger procedures.

Your credit card information is stored in a PCI-compliant software program that is encrypted. Once the number is stored, no one can see the information. You reserve the right to revoke the card at any time and can also manage the card on file in the patient portal.

If you are not comfortable leaving a card on file, please speak with us to discuss other options.

We want to focus on patient care and not on reminders to patients to pay their balances. Thank you for understanding why we find it necessary to institute this policy.

Other Bills

If you should undergo a biopsy in our office, your insurance carrier will be billed separately by the laboratory. You will receive a separate bill from the laboratory for any uncovered charges. We use two different laboratories so you may receive a bill from NYU Dermatopathology or Mudgil Dermatopathology. You must contact the proper lab regarding any billing issues related to the pathology bills.

Failure to pay:

Any unpaid balance that exceeds 45 days may be sent to an outside collections service and will incur any associated fees and costs. The patient or guarantor will be responsible for all associated costs including interest from the payment due date.

I _____ have read the above disclaimer and fully understand my financial responsibilities to Lance Brown, MD PLLC.

I _____authorize payment of medical benefits to the physician for services provided.

Credit Card Information:

Credit Card Number:_____

Expiration Date_____ Security Code:_____

_____

Patient or Responsible Party Signature

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Dermatology Medical History

Patient: _____ Date of Birth:: ___/___/___ Today's Date: ___/___/___

Are you allergic to any medications? ❑ YES ❑ NO If yes, list below:
1. _____ 2. _____

List all medications you are currently taking (including prescriptions, over-the-counter meds., vitamins, and herbals):
1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

Lungs:	YES	NO
Bronchitis	❑	❑
Emphysema	❑	❑
Asthma	❑	❑
Chronic Cough	❑	❑
Morning Cough	❑	❑
Shortness of Breath	❑	❑
Wheezing	❑	❑

Cardiovascular:	YES	NO
High Blood Pressure	❑	❑
Chest Pain	❑	❑
Heart Attack	❑	❑
Heart Murmur	❑	❑
Irregular Heartbeat	❑	❑
Phlebitis	❑	❑
Inflammation of vein	❑	❑
Blood clots	❑	❑
Pacemaker	❑	❑

Other Systemic:	YES	NO
Diabetes	❑	❑
Excessive thirst/hunger	❑	❑
Amputation	❑	❑
Thyroid	❑	❑
Kidney	❑	❑
Dialysis	❑	❑
Bladder	❑	❑
Frequency/burning	❑	❑
Gastrointestinal		
Stomach absorptive disorder	❑	❑
Nausea, vomiting, diarrhea when taking antibiotics	❑	❑
Yeast infection when taking antibiotics	❑	❑
Arthritis/Joint Deformity	❑	❑
Arthralgia	❑	❑
Limited motion	❑	❑
Artificial joint	❑	❑
Convulsions, Epilepsy or Seizures	❑	❑
Fainting	❑	❑

List any other diseases or conditions: _____

List surgical procedures you have had in the last 6 months: _____

Skin: Have you ever had skin cancer? ❑ YES ❑ NO
Has anyone in your family had skin cancer? ❑ YES ❑ NO
Do you have a history of any specific skin diseases? ❑ YES ❑ NO If yes, _____
Do you have problems with healing ❑ YES ❑ NO
Do you develop keloids (scars) after surgery ❑ YES ❑ NO
Do you bleed easily? ❑ YES ❑ NO
Do you develop skin rashes in reaction to ❑ Medications ❑ Food ❑ Environment ❑ Bandages ❑ Topical Neosporin ❑ Other _____

Social History:
Do you drink alcohol? ❑ YES ❑ NO If YES _____ drinks per day
Do you use IV drugs? ❑ YES ❑ NO If YES, what? _____ How often? _____
Do you smoke? ❑ YES ❑ NO If YES, how much: _____
Have you had or have you been exposed to HIV (AIDS)? ❑ YES ❑ NO

Please answer the following questions:
(Women) Are you pregnant? ❑ YES ❑ NO Due Date: ___/___/___
What is your occupation? _____ Hobbies? _____

Completed by: ❑ Patient ❑ Medical Assistant _____ Initials
_____ Signed by Patient ___/___/___ Date
_____ Reviewed by ___/___/___ Date

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HIPAA PRIVACY CONSENT

PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before sighing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health Information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

• Protected health information may be disclosed or used for treatment, payment orhealth care operations

• The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice

• The Practice reserves the right to change the Notice of Privacy Policies

• The patient has the right brestrict the uses of their informationbut the Practice does not have to agree to those restrictions

• The patient may revoke this Consent in writing at any time and allfuture disclosures will then cease

• The Practice may condition treatment upon the execution of this Consent.

This Consent was signed by: _____

(Printed Name – Patient or Representative)

Relationship to Patient (if other than patient): _____

Signature:_____

Date: _____

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HEALTH INFORMATION EXCHANGE, CARE EVERYWHERE AND HEALTHIX CONSENT FORM

Please Fax signed consents to: **917-829-2096**	**Patient MRN/Patient ID:**	

In this Consent Form, you can choose whether to allow the health care providers listed on the NYU Langone Medical Center Health Information Exchange ("NYULMC HIE") website http://health-connect.med.nyu.edu/ ("HIE Participants") and non-NYU health care providers who may request access to your medical records for purposes of current treatment ("Care Everywhere Providers") to obtain access to your medical records through a computer network operated by the NYULMC HIE. In order for a Care Everywhere Provider to know that information may be available through the NYULMC HIE, you must tell them that you were/are a patient of an HIE Participant and that such information may be available upon request. This can help collect the medical records you have in different places where you get health care, and make them available electronically to the providers treating you.

You may also use this Consent Form to decide whether or not to allow employees, agents or members of the medical staff of NYU Hospitals Center to see and obtain access to your electronic health records through Healthix, which is a Health Information Exchange, or Regional Health Information Organization (RHIO), a not-for-profit organization recognized by the state of New York. This can also help collect the medical records you have in different places where you get healthcare, and make them available electronically to the providers treating you. This consent also gives your permission for any NYU Langone Medical Center program in which you are a patient or member, to access your records from your other healthcare providers authorized to disclose information through Healthix. A complete list of current Healthix Information Sources is available from Healthix and can be obtained at any time by checking the Healthix website at http://www.healthix.org or by calling Healthix at 877-695-4749. Upon request, your provider will print this list for you from the Healthix website.

YOUR CHOICE WILL NOT AFFECT YOUR ABILITY TO GET MEDICAL CARE OR HEALTH INSURANCE COVERAGE. YOUR CHOICE TO GIVE OR TO DENY CONSENT MAY NOT BE THE BASIS FOR DENIAL OF HEALTH SERVICES.

The NYULMC HIE and Healthix share information about people's health electronically and securely to improve the quality of health care services. This kind of sharing is called ehealth or health information technology (health IT). To learn more about ehealth in New York State, read the brochure, "Better Information Means Better Care." You can ask your health care provider for it, or go to the website www.ehealth4ny.org.

PLEASE CAREFULLY READ THE INFORMATION ON THE FACT SHEET BEFORE MAKING YOUR DECISION.
Your Consent Choices. You can fill out this form now or in the future. You have the following choices:

Please ☑ Check

☐ **1. I GIVE CONSENT to ALL of the HIE Participants listed on the NYULMC HIE website and Care Everywhere Providers to access ALL of** my electronic health information through the **NYULMC HIE** and **I GIVE CONSENT to ALL employees, agents and members of the medical staff of NYU Hospitals Center to access ALL of** my electronic health information through **HEALTHIX** in connection with any of the permitted purposes described in the fact sheet, including providing me any health care services, including emergency care.

☐ **2. I DENY CONSENT to ALL of the HIE Participants listed on the NYULMC HIE website and Care Everywhere Providers to access** my electronic health information through the **NYULMC HIE** or **HEALTHIX** for any purpose, *even in a medical emergency*.

NOTE: UNLESS YOU CHECK THE "I DENY CONSENT" BOX, New York State law allows the people treating you in an emergency to get access to your medical records, including records that are available through the NYULMC HIE. IF YOU DON'T MAKE A CHOICE, the records will not be shared except in an emergency as allowed by New York State Law.

PRINT Name of Patient	Patient Date of Birth
Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)